Long Term Care Supports & Services
Advisory Commission
Finance Workgroup
Michigan Home Health Association
Meeting Minutes - February 11, 2008

1. Welcome and Introduction of Workgroup Members

2. Appointment of Secretary

3. Action Item Follow-Up
   a. Education
      i. Reimbursement
         1. Managed Care Feasibility Grant – Head:
            - 1 long term care provider until they don't need it anymore = licensed managed care entity.
            - Only non-competitive for the pilot – no willing provider.
            - Person enters a planning process that allows designation of financing of services.
            - More flexibility in types of services
            - Risk - # of people who would enter.
            - People on MI Choice waiting list meet NH LOC but stay home.
            - City of Detroit – waiting list 900 – 50% met NH LOC usually have some minimal other help from AAA.
            - 12-13% die while on the waiting list or go to NH.
            - Would hold pilot in Detroit with Detroit AAA.
            - When applied to just the LOC – 25% met.
            - Star Plus for TX Minnesota
            - Way of looking at the woodwork effect
            - WI experience – NH LOS decreased average 8 months to 5 months
            - Cost differential helped pay the difference to cover more people
            - Feasibility study to get a) how many people at what cost
            - what models have what cost
            - Array of services: b) waiver – state plan services (as is now), additional services paid for from savings from others using NH less, c) waiver – MI Choice, specialized residential care
            - 300 NH = 260 HCBS
            - Voluntary enrollment but only way to get c) waiver developed within SPE idea
            - Detroit only 1 waiver agent
            - Primary health care carved out for now
            - Not integrated with M/C
            - MI Choice waiver already capitated (?) so would look to work through waiver agents for this program
            - Michigan is one of few if maybe only state set up with risk like we do with waiver _____ contracting

      ii. Medicare and Medicaid Federal Match
         1. Update
            a. Advocacy – Farmer
            b. Legislative Action – Orme & Chesny

      iii. Long Term Care Insurance
         1. AAHSA Proposal - Mitchell

      iv. Reimbursement Models

4. Workgroup Member Assignments
   Estate Recovery – Caroline
   a. Reimbursement Model Chair – Mitchell

5. Action List

6. Future Meeting Schedule

7. Member Comments

Financing Long-Term Care
A Framework for America
American Association of Homes and Services for the Aging
2006

The vision of the American Association of Homes and Services for the Aging is for all Americans to receive the care they need, when they need it, in a place they call home. However, the current system for financing long-term care presents serious financial barriers for the elderly and others to do so. As the baby boomers age into retirement, the need for long-term care will double over the next three decades, turning current problems into a far greater national crisis. In 2004, AAHSA leaders convened a Finance Cabinet to recommend to the Board, after appropriate study, a position with respect to a model for future financing for long-term care. This document presents the Finance Cabinet's recommendations and the rationale for its decisions.

The Challenge: Why Change is Needed

Ten million Americans today (40 percent under age 65) need long-term care, but our current financing system leaves many with unmet needs and catastrophic costs. Individuals and families shoulder the primary burden for providing help—both through payment for professional services in a variety of settings and through the substantial economic value of the donated services families and communities provide.

□ **Needs are unmet** among the poorest of us, despite families' considerable efforts and substantial public expenditures. Over half of those covered by both Medicare and Medicaid who live in the community have unmet needs for long-term care with serious consequences such as going hungry, soiling themselves, or being unable to bathe or wear clean clothes.

□ **Costs are catastrophic for those who need extensive or lengthy care**. In 2005, the average cost of a private room in a nursing home was $203 per day; the cost of home health aides averaged $19 per hour and a homemaker-companion cost $17 per hour.

Among those turning 65 today, 20 percent will need care for more than five years.

□ **The increasing burden on Medicaid is unsustainable**. Medicaid costs for long-term care will double (constant dollars) by 2025 and increase five-fold by 2045 (Figure B).

□ **More money will need to be spent; where will it come from?** Desirable policy choices such as expanding home and community-based services can only marginally improve the financial outlook; increasing labor costs and the sheer numbers of retiring baby boomers drive long-term care expenditures, overwhelming conventional policy options.

Recommendations

If the nation does nothing to change the current financing system, unsustainable pressure on state budgets and Medicaid will lead either to abandoning all other state responsibilities, such as education, or abandoning ever-larger proportions of those with long-term care needs. Merely federalizing long-term care would simply shift the costs to another locus, where growing Medicare costs compete for tax dollars. The Finance Cabinet concluded that additional money would be needed but that a new system for raising it and paying for long-term care must be implemented to address both current and future problems in a manner that better shares the burden.

□ Insurance, not welfare

The nation should adopt an insurance model for financing long-term care, rather than relying so heavily on Medicaid—a pay-as-you-go welfare model that leaves many with unmet needs and requires that people impoverish themselves before qualifying. The need for long-term care is a risk, not a certainty, with catastrophic financial consequences for the unlucky. An insurance model can spread the risk more equitably and, if implemented in sufficient time, prefund the baby boomers' coming explosive needs.

□ Universal participation

A system should be developed to provide as close to universal coverage as possible because all Americans, to the extent feasible, should have access to long-term care without impoverishing themselves and their families and because substantially mitigating expected future Medicaid costs requires nearly universal insurance coverage with good protections.

The Cabinet does not envision an insurance system that will cover—as an entitlement—all long-term care costs for every American. Even if all or most Americans are enrolled in an insurance plan, there will be costs not covered by the plan. Germany, for example, expects those who participate in its national long-term care insurance to pay about 25 percent of the cost of nursing home care—roughly the room and board costs. Some may wish to purchase extra wraparound insurance to cover full costs; some may pay with private funds; and some will have inadequate funds for either. Thus the Cabinet assumes that a residual Medicaid system will need to be retained to cover these costs as well as to cover people who fall through the cracks for one or another reason.

Universal participation could be achieved by a mandate, just as mortgage holders require home insurance and states require helmets or seatbelts. But it may also be possible to achieve nearly universal participation by automatically enrolling workers and requiring those who do not want to participate to actively "opt out."

□ Public insurance, financed by premiums, as the foundation
Given that the goal is universal (or nearly so) participation in an insurance system providing the greatest benefits for the lowest costs, what is the best way to get there? The Cabinet concluded that while private long-term care insurance should remain an important component of a national strategy, the foundation of that strategy should be a broad-based public insurance program with low overhead costs and an all-inclusive risk pool. The Cabinet concluded that even if private policies improved, insufficient numbers of people who otherwise might become Medicaid's responsibility could afford to and could be persuaded to buy private insurance, even if—as some suggest—Medicaid eligibility was tightened and/or tax incentives were increased.

Getting close enough to universal coverage will require a mandate or near mandate; that in turn, the Finance Cabinet concluded, requires that an equitable, affordable public insurance program be available.

The public insurance program should be financed by premiums, not by general tax revenues. The premiums should be established in line with benefits to produce an actuarially sound program. People with very low incomes should receive financial assistance to purchase the insurance.

□ A disability insurance model, with cash at least one of the benefits; greater benefits paid to those with greater functional needs Long-term care is more suited to a disability (cash payments) model because long-term care services and supports are concerned with maintaining well-being in the face of disability.

Consumers can better judge what's best for them in long-term care compared to a greater need for professional judgment in medical matters. Workable models of cash payments exist in both the successful Cash and Counseling demonstrations operated in three states and the German system implemented a decade ago.

□ Administration by a federally chartered organization responsible for managing the premiums, investments and payments
The goal is to have the finances managed outside of the federal treasury and budget, similar to the way funds are managed in a number of the European health and long-term care insurance systems. To maximize consistency, the disability assessment and appeals system should be a centralized function. New

systems for providing help managing choices and accessing services could build on advanced state models and likely would be contracted to public or private organizations with expertise.

Principles and Values

The Cabinet began its work discussing characteristics of an optimal long-term care system and how financing might relate to that goal. A financing system should:

- Promote and support informal caregivers
- Provide benefits equitably
- Promote consumer choice
- Promote quality or care and life; promote consumer-defined quality
- Promote access to technology and its integration into the continuum of care
- Support integration of medical and social models of care
- Promote and reward innovation, efficiency and competition
- Provide a safety net for those without resources
- Promote financial responsibility—personal and national

1 For a description of the structure of this model, see: http://aspe.hhs.gov/daltcp/reports/modampes.htm

Core Principles

Continued discussion and consideration of the results of the House of Delegates' 2004 Survey of Principles and Values led the Cabinet to conclude that a financing system should embody three core principles:

- **Consumer choice:** Promote consumer choice in quality and services;

- **Financial responsibility:** Promote personal financial responsibility and stewardship of provider and public resources;

- **Equity:** Promote equitable availability of benefits

Prepaid Long-Term Care Health Plan Project

Overview: The plan is a collaborative effort by MSA and OLTCSS to submit a 1915 b/c combination Medicaid waiver to the Centers for Medicaid and Medicare Services. The waivers would create a Prepaid Long-Term Care Health Plan. DCH, OLTCSS and MSA would initiate the pilot in early FY 09. It is consistent with DCH attempts to improve health care and quality of life for Michigan Citizens. Reimbursement would be on a capitated basis. This approach is central to LTC reform by providing support for a Person-Centered approach to informed consumer choice in accessing a full-range of long-term care service options. In the Person-Centered Planning process, individuals develop their options, make their own decisions that are driven by their life goals and priorities, and have the support of allies in planning, developing, and implementing their supports and services. This approach also supports the principle of Money Follows the Person as participant care needs shift. The challenge has been framed by, and is consistent with, the recommendations and values from the LTC Task Force.

Workgroup Development: MSA and OLTCSS staff are participating in a series of workgroups to develop the eligibility, service definitions, provider qualifications, quality assurance, rates, and information services material necessary to fully define the plan and to complete the Medicaid waivers. A concept paper has been submitted to CMS, a feasibility study will determine if the proposed plan can cost neutral as well as cost effective, as compared to the regular State Plan services. The eligibility for the proposed plan is limited to Medicaid beneficiaries who have a Nursing Facility Level of Care and are elderly or people with disabilities

Outcomes: The expected outcomes for the project are to: enact "Money Follows the Person" within the Medicaid program for those eligible for long-term care services, improve quality of life options for people requiring services, go beyond the capacity constraints of the current MI Choice Waiver, provide entitlement access for persons eligible for the plan, support participant choice and empowerment across a full range of long-term care supports and services, assure appropriate use of nursing facilities and home and community-based services, provide local alternatives for nursing facility closures, address unmet needs through reinvestment of savings, and manage the use of limited funding.

Detroit: The site which as been identified for this project is Detroit and the OLTCSS is working with the Detroit Area Agency on Aging and the Detroit Long-Term Care Connections to understand the concepts and plans necessary to implement this type of a service for current MI Choice participants, those on the waiting list, and individuals who select to transition out of Nursing Facilities. The plan is voluntary for all participants, but they would not enjoy a choice between several plans at this time. Current State Plan services would continue for all beneficiaries that choose not to participate.

Consumers: Two consumer advisory groups are forming to make suggestions for this project. One will focus on statewide issues and the second will be specific to Detroit implementation.

Services Provided: This Prepaid LTC Health Plan will offer a range of supports and services to assist Medicaid beneficiaries with successful community living by coordinating their long-term care supports and care in a person-centered program which includes nursing facilities, assisted living, transition services, community living supports, and other long-term care services.

Similar State Plan: The Wisconsin Family Care Program is a similar package of supports and services that has grown in Wisconsin and demonstrated quality and cost effectiveness.